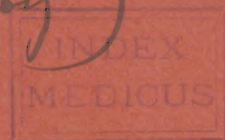


McCurdy (S - Le Roy)



# HIP JOINT DISEASE

## WITH CASES.

BY

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## HIP JOINT DISEASES WITH CASES.\*

BY STEWART LE ROY M'CURDY, M.D., DENNISON, OHIO.

One apology for using a portion of your valuable time in considering the subject of hip joint disease is to review the early and most prominent symptoms, and what appears to me to be the most successful mode of treatment, for my own benefit, as well as to present the same facts to you, so that we may be all more readily prepared to differentiate this most subtle disease in its earlier stages, and by the institution of a vigorous, mechanical and systematic course of treatment, cut short the affection that may be the incipency of untold agony and cruel deformity.

Like many other obscure afflictions, we may not be watching for them, and possibly fail to locate the true trouble and subject our patient to an unnecessary course of treatment.

Caxalgia or *coxarum morbus* has been divided by Sayre

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into three stages: First, stage of irritation before effusion; second, stage of effusion and apparent lengthening; third, stage of shortening or ruptured capsule.

The more prominent symptoms of the first stage may be summed up briefly as follows: Slight stiffness in the affected joint, especially in the morning, the thigh slightly flexed on the pelvis, and the leg fixed on the thigh, this position being that assumed by the patient while walking. To allow the foregoing position, it will be observed that the patient throws the body slightly forward and toward the affected side. The foot is slightly everted and the leg thrown forward.

One of the earliest and most misleading symptoms is pain in the knee upon the affected side, which, owing to its remoteness from the real seat of the trouble, is frequently mistaken and treated for rheumatism or neuralgia of that joint.

I desire now to make indelible on the minds of my hearers this one symptom, which, if remembered, will be the first fragment to make a true diagnosis. Never allow a child suffering with pain in the knee, not accompanied with any apparent symptoms of disease of that joint, to pass your notice without suspecting this malady. *To suspect will be to diagnose.* The buttock upon the affected side will be found to be somewhat flattened and lower. The gluteo-femoral is less distinctly marked on the affected side. By laying our patient down on a table on his back, nude, every motion of the thigh will carry the pelvis with it. For instance, when the thigh is extended, the illum will be thrown further from the table on the diseased side, and when flexed again, it is thrown down against the table. While there may be no pain in the affected joint in the earlier course of the disease, pain can generally be produced by gently tapping the bottom of the foot with the legs extended, and also by suddenly pressing the trochanter while the pelvis is being supported on the opposite side with the other hand.

The second stage, or that of effusion or apparent lengthen-

ing, is pretty much the same as that of the first. The position assumed by the patient while walking and flexion of the thigh upon the pelvis is as described heretofore. All symptoms are more marked, and the pain in the hip now begins to show itself more prominently.

In all bone diseases the pain is more severe at night, and especially is this true of the so-called strumous diathesis, or syphilitic affections. The trouble beginning primarily either as a synovitis, or osteo-epiphysitis, produces very much the same train of symptoms, the exception or variation being in the earlier distension of the joint bag in synovitis, and the absence of the same in central otitis. A further consideration of symptoms would be but to repeat what is known to you all, and a needless consumption of time, for after a case is made out our duty is not to arrange a tabular list of symptoms and make a dreamy comparison of the same with other cases, but rather take advantage of an opportune moment and institute treatment that will give you a brilliant result.

No form of hip brace thus far devised has given universal satisfaction to its inventor, much less to those who endeavor to select, apply and carry out the demands in a given case, when he is lacking in mechanical ingenuity. From the fact that every stage demands certain variation in the form of splint used, no splint unless applied with a ripe knowledge of the case, and genius enough to adjust a brace, can expect to give satisfaction.

Of the innumerable splints that have been devised for this purpose, the Davis', Andrews', Sayre's, long, short, infants, and night, Stephen Smith's, Hutchinson's, Washburn's, Shaffer's, Duncan Eve's, Taylor's, Roberts' and Stillman's, have been most successfully used. As a matter of fact the Sayre, in the various modifications, has enjoyed almost universal supremacy with the country surgeons, who found it most convenient to adopt some form of brace. All the foregoing braces differ in detail, but have for their main purpose the protection of the joint. Some of them secure fixation, others articular motion,

others endeavor to relieve enter-articular pressure, while others say such procedure is impossible, impractical and positively injurious.

After making a pretty thorough inquiry into the various braces and devices now in vogue, I must say it is quite difficult to endorse the opinions of one orthopedist and reject the views of another equally as skilled and time-tried.

In the first stage, or the stage of irritation and limitation of motion, per Sayre's classification, Roberts advises, when the disease begins as a central osteo-epiphysitis, drill through the greater trochanter and neck of the femur to the supposed or suspected seat of the disease, and thoroughly ream out the morbid area and establish free drainage.

Mr. Stokes of Dublin, advises early drainage of the diseased area and gives cases illustrating his success with the same.

M. Boeckel, before the French Surgical Congress, advocates the early resection of the head, holding that a case of hip disease cannot be cured until the head of the femur undergoes molecular disintegration and absorption, or resection, and the earlier resection is performed the more probable our patient is to escape tubercular infection of the more vital organs.

Sayre and others of this country, who follow him, have performed early resection with very gratifying results.

When the trouble is primarily a synovitis, surgeons have advised and practiced early drainage of the synovial sack.

Without entering into a description of the various braces heretofore referred to, for all of which we must have great respect, I will at once proceed to describe a modification and combination of some of them, as illustrated here, which have given me greatest satisfaction in my limited experience in treating hip-joint disease.

Verify your diagnosis, and then institute a course of

treatment that will produce as near physiological rest to the joint as possible.

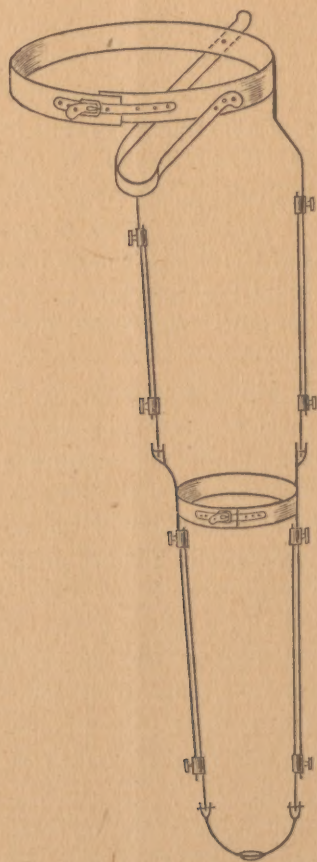
Assuming that the trouble is, primarily, either a synovitis or an osteo-epiphysitis, both being inflammatory diseases of the joint structures, and while they differ widely in their early course, they both produce pretty much the same impression upon the system. All the muscles crossing, or whose tendons pass over the affected joint, are in a state of spasmodic contraction, due to reflex nervous irritation. As a result of this reflex nervous irritation and resultant muscular spasm, the bones entering into the formation of the joint involved are pressed more firmly together, and if the interposed synovial membrane be engorged, the extent of the lesion will be increased thereby, which in turn increases the muscular spasm, again increasing inter-articular pressure, and so on, until dislocation is the result.

If the trouble be primarily a synovitis, it can be readily seen that to lift these bones from each other (if such be possible), and allow the inflamed membrane to rest, it will have more chance to repair; while on the other hand, to allow this pressure to continue will be but to allow the inflammation to increase, and a consequent destruction of all structures involved.

Or if the trouble be primarily a central ostitis, even advanced to where the head of the bone must dissolve and undergo absorption, according to Boecker of Paris, the duty of the attendant is to arrange a course of treatment that will allow our patient to go on to recovery with a minimum of deformity.

To obtain the foregoing results, one must apply a brace that will hold the limb in its normal position, and retain it there throughout the course of treatment. This is best done, it appears to me, by the brace herewith presented, which, as you see, is composed of a double system of bars extending from a belt around the pelvis on the outside and a perineal crutch upon the internal side of the thigh down to a stirrup fastened to the bottom of a

neatly fitting shoe. These double systems of bars are so arranged that they slide upon each other and are held together by a collar from the proximal ends of the bars. You will also observe a button projecting from the collar at the proximal ends of all the bars. If an elastic is



thrown about these buttons, you can readily see they are thrown closer together, which increases the distance between the distal ends, one fixed point being at the sole of a neatly fitting shoe and the other at the perineum and pelvis. These points being fixed, the elastics be-

ing thrown about the pins, the traction made upon the femur's head as it rests in the acetabulum can always equal the demands of the case as thought desirable by the surgeon, and the interposed synovial membrane in a state of congestion will be relieved of, at least, a portion of its pressure, which will, theoretically at least, allow the inflammation to subside.

The objects to be sought in the adjustment of this brace are two-fold: First, secure fixed points for the brace; second, avoid rigidity.

The Gurdon Buck weight and pulley extension has been used for this trouble in all stages, but it has been unsatisfactory, principally for the reason that there is no definiteness in the degree of traction. A definite degree of traction must be secured and at the same time avoid the iron-clad encasement of the member. Braces secured to the member by adhesives are not as satisfactory as those adjusted to fixed points. Adhesions must be used in wrist and phalangeal affections, but in hip cases they should never be used. Elastic traction, early applied, not only affords rest to the inflamed synovial membrane of the affected joint, by overcoming muscular spasms, but it also holds the head of the femur in its normal position during the stage of destruction and absorption of the head of the femur, and allows the patient to recover with very little deformity.

Case 1.—O. C., girl, aged 6; fell and sustained a contusion of the left hip. In a few months she complained of a pain in the knee, which was treated for rheumatism. In about six months the mother noticed a perceptible atrophy and redness of temperature of the affected side. I saw her eighteen months after injury and had no trouble in making out a case of morbus coxaris. There was one-half inch of thigh atrophy and one-fourth of leg atrophy. The member was practically useless and had been for months. She had been using crutches for months. I took measurements and had a brace made for her, similar to the one I show you. From this time on she began to

improve, and went to school the entire nine months afterwards, being one of the honor members. Sleep was impossible before application of the brace, and after the application she never spent a wakeful night, appetite improved, and in every way she went on to a good recovery. She had an abscess on the anterior surface of the thigh, which was aspirated, and afterward a small sequestrum was removed. With the brace she went through the course of the disease with comparative comfort, and came out with little deformity, and about an inch of shortening.

Case 2.—J. E., male, aged 5, now under treatment; was treated for months for rheumatism, finally fell into the hands of a doctor who diagnosed hip disease and sent the patient to a neighboring city for treatment, and while there he was in a hospital with Gurdon Bucks extension tugging aimlessly at his diseased member, without effect however, for while under this treatment the head of the femur underwent molecular disintegration and spontaneous dislocation. When I saw him he was suffering great pain in the hip, with extreme emaciation and deformity. I adjusted a brace as per illustration and he began to improve, and was soon about on crutches. As this case is still under treatment, I cannot report more than progress, but hope to be able to give you the results of further treatment at our next meeting. Other cases might be given, but as our time is limited, I defer reports until some future occasion.



